

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #13, 14, 15 & 16 Film #G395 12/1/67 ph

15293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15298

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island				c. LENGTH OF STAY IN 1b Tompkinsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Water at Cobb Island, Md.				d. STREET ADDRESS Tompkinsville, Md.			
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS CALVIN BRISCOE				4. DATE OF DEATH Month Day Year November 14 19 67			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1942	9. AGE (In years last birthday) 25 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sylvester Briscoe				14. MOTHER'S MAIDEN NAME Mary C. Dent			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4290 IMMEDIATE CAUSE (a) Drowning DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Subject supposedly drowned accidentally					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. ? ? 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water		20f. (City or town) (County) (State) Cobb Island Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward F. Wilson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county) November 15, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Shiloh Methodist		23d. LOCATION (City or Town) (County) (State) Newburg, Charles, Md.	
24. FUNERAL DIRECTOR Berry Funeral Home, Potoskey, Md.				25a. REC'D BY REGISTRAR DATEN 27 1967		25b. REGISTRAR'S SIGNATURE O. Charles Judge	

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15294

15299

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata c. LENGTH OF STAY IN 1b LaPlata d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg d. STREET ADDRESS Newburg, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH BROOKS				4. DATE OF DEATH Month Day Year November 2, 19 67			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-22-1897	
9. AGE (In years last birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) No		10b. KIND OF BUSINESS OR INDUSTRY No		11. BIRTHPLACE (State or foreign country) Upper Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME JOSEPH W BROOKS		14. MOTHER'S MAIDEN NAME Susie Brooks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4221 (c) 4221	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 6:45 p.m. 11/2 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Virginia		20f. (City or town) (County) (State) Virginia	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Werner U. Spitz, M.D.				22. DATE SIGNED 11/3/67			
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11/6/67		23c. NAME OF CEMETERY OR CREMATORY Spidok Mt. Church		23d. LOCATION (City or Town) (County) (State) Newburg Md	
24. FUNERAL DIRECTOR Leroy L. Berry - Huntingtown				25a. REC'D BY REGISTRAR DEC 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JOHN W. BR-12

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UPPER MOUNTAIN
Base BR-12
10.15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
15300									
1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>15300</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dayton</u> d. STREET ADDRESS <u>15300</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>ELWOOD</u> Middle <u>EARL</u> Last <u>BURCHELL</u>					4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>5-1-09</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>10</u> Hours <u>10</u> Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DAIRY - PRODUCER SALES MAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>King Geo Co Va.</u>			11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HEARST CLAY BURCHELL</u>					14. MOTHER'S MAIDEN NAME <u>LULA ROLLINS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>15300</u>		17. INFORMANT <u>Michael H Burchell 501 High St Alex Va</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>1 yr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10-12-1967</u> to <u>11-10-1967</u> , that (I) (we) last saw the deceased alive on <u>11-2-1967</u> , and that death occurred at <u>1:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>E J Fedele</u>					22b. DATE SIGNED <u>11-10-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>E J FEDELE</u>					22d. ADDRESS <u>15300</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/13/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>Alex. Va</u>		
24. FUNERAL DIRECTOR <u>EVERLY - WHEATLEY</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					DATE NOV 14 1967				

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15296

16862

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>08-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JAMES J BUTLER</u> First Middle Last			
DATE OF DEATH <u>11 29 67</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-94</u> 9. AGE (In years and day) <u>72</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Ret.-USNOS</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Butler</u>		14. MOTHER'S MAIDEN NAME <u>Julia Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>217-28-4264</u>	
17. INFORMANT <u>Alice B. Butler, Newburg, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850 X</u> DUE TO <u>Asphyxiation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fell from boat while</u> DUE TO <u>oystering (Lancaster Mar)</u> (c) <u>11-27-67</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between death and death</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fell from boat</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-29-67</u> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Newburg, Md</u>	20f. (City or town) (County) (State) <u>Charles Co. Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u> M.D.		22. DATE SIGNED <u>11-29-67</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Newport, Charles Co., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec. 2, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Newport, Charles Co., Md.</u>
24. FUNERAL DIRECTOR <u>Archart Funeral Home Inc., La Plata, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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15297

CERTIFICATE OF DEATH

15301

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DELLA Middle ANN Last ELIZABETH CHESLEY		4. DATE OF DEATH Month November Day 13 Year 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 5, 1900
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (County & State, or foreign country) Charles County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hill		14. MOTHER'S MAIDEN NAME Bertha Donelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unkown	
17. INFORMANT Rufus M. Chesley-Husband-Newburg, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) C.U.A. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/13 , 19 67 , to 11/13 , 19 67 , that (I) (we) last saw the deceased alive on 11/13 , 19 67 , and that death occurred at 8:15 M, from causes and on the date stated above.			
22a. SIGNATURE Arturo M. Monteiro		22b. DATE SIGNED 11/14/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro		22d. ADDRESS La Plata, Md. 20646	
23a. BURIAL, CREMATION, REMOVA (Specify) Burial	23b. DATE THEREOF 11/16/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery	23d. LOCATION (City or Town) (County) (State) Issue, Maryland
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE NOV 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head Md c. LENGTH OF STAY IN TB 8-Days d. NAME OF HOSPITAL (If not in hospital, give street address) Physicians Memorial Hosp, LaPlata Md		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanjemoy Md d. STREET ADDRESS Physicians Memorial Hosp, LaPlata Md e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert D. Diggs		4. DATE OF DEATH 11-10-67 Month Day Year 19	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-1886
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Nanjemoy Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Diggs	
14. MOTHER'S MAIDEN NAME Mandy Jackson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> None	
16. SOCIAL SECURITY NO. 214-42-7929		17. INFORMANT Park Diggs-Brother Address Marbury Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerosis General DUE TO (c) Aging Process		INTERVAL BETWEEN ONSET AND DEATH Indefinite Indefinite Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-3-67 , 19 67 , to 11-10-67 , 19 67 , that I last saw the deceased alive on 11-10-67 , 19 67 , and that death occurred at 12-25 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Indian Head Md DATE SIGNED 11-10-67			
ACTUAL SIGNATURE James E. Andrews MD		PHYSICIAN'S NAME (Type) James E. Andrews MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE James E. Andrews MD		24a. REC'D BY REGISTRAR DATE NOV 17 1967	
24b. REGISTRAR'S SIGNATURE J. E. Andrews MD			

FOR STATE
HEALTH DEPT

15299

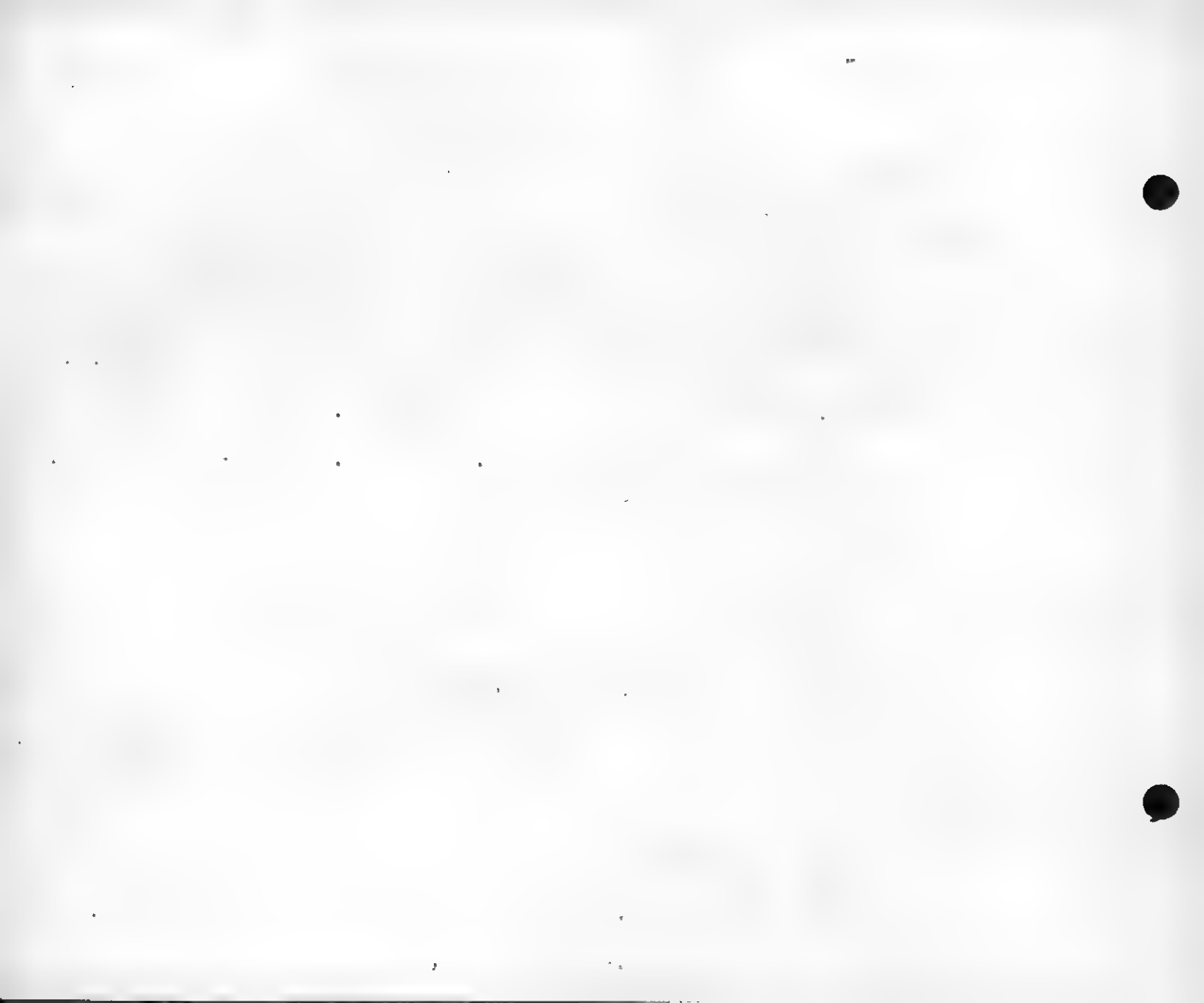
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15303

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Indian Head La Plata c. LENGTH OF STAY IN lb LaPlata (Rural) d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LaPlata (Rural) d. STREET ADDRESS Box 507 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle HOWARD Last MORGAN		4. DATE OF DEATH Month November Day 21, Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 5, 1949 9 AGE (In years last birthday) 18 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY College	11 BIRTHPLACE (State or foreign country) Maryland 12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME HillEn J. Morgan		14 MOTHER'S MAIDEN NAME Laura R. Rees	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. Unknown	17 INFORMANT Mr. Hillen J. Morgan-La Plata, Md. Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cranio-cerebral Injury DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.) Subj. thrown from motorcycle	
20c. TIME OF INJURY Month, Day, Year 12 pm 11/21 1967	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY Home, farm, factory, street, office bldg, etc.) School	20f. (City or town) (County) (State) Charles Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county) 11/24/67	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/25/1967	23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery	23d. LOCATION (City or town) (County) (State) Chapel Point, Md.
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md. ADDRESS		25a. REC'D BY REGISTRAR NOV 29 1967 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>Rt. 234 Wicomico, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Physicians Memorial Hospital</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Plater</u>		4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1885</u>
9. AGE (in years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Henry Plater</u>		14. MOTHER'S MAIDEN NAME <u>Sarah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>Fornie Plater</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Thrombocytopenia</u> (b) <u>Chronic Lymphatic Leukemia</u> DUE TO <u>Chronic Lymphatic Leukemia</u> (c) <u>Chronic Lymphatic Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov</u> , 19 <u>67</u> , and that death occurred at <u>8 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Sp, city) <u>Burial</u>		23b. DATE THEREOF <u>12-2 -6 7</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Ch. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Newport, Chas. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Martell Adams</u>		ADDRESS <u>Aguasco, Maryland</u>	
25a. REC'D BY REGISTRAR <u>DEC 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



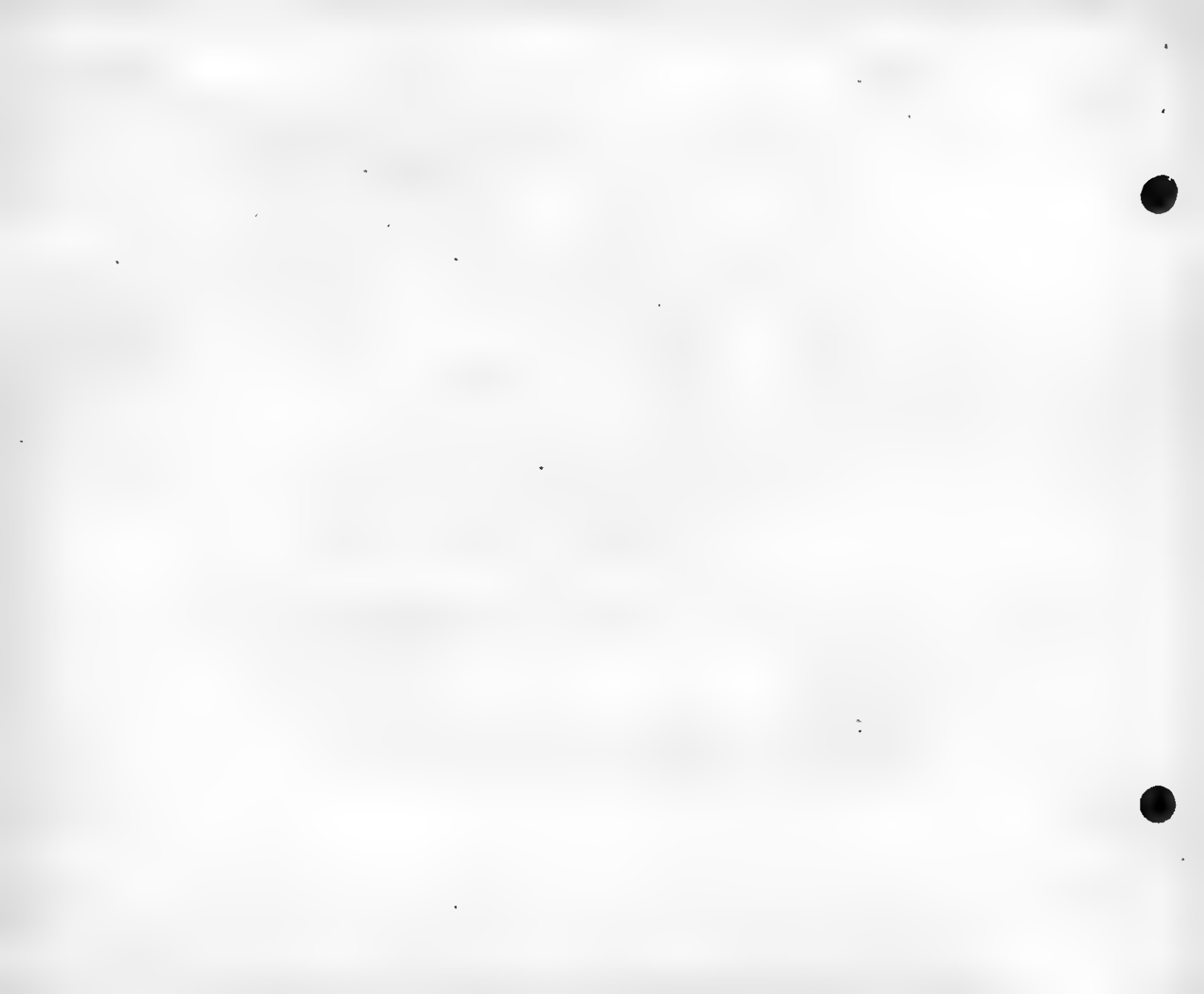
CERTIFICATE OF DEATH

15305

1 PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Plains</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. STREET ADDRESS <u>Billingsley Rd</u>	
3 NAME OF DECEASED (Type or print) <u>EVA</u> <u>McLond</u> <u>POTTER</u>		4 DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1967</u>	
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov 24, 1894</u>
9 AGE (In years last birthday) <u>72</u> yrs		10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR IND. STRY <u>Paul's Mfg.</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Ches</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13 FATHER'S NAME <u>John McLond</u>	
14 MOTHER'S MAIDEN NAME <u>UNK</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>30-107-7136</u>		17 INFORMANT <u>J. F. Potter, White Plains, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac dilatation</u> DUE TO (b) <u>arteriosclerotic hypertension</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>Oct</u> Day <u>19</u> Year <u>1967</u> Hour <u>—</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>11-11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-10</u> , 19 <u>67</u> , and that death occurred at <u>3A</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>F.M. Johnson</u>		22b. DATE SIGNED <u>11-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.M. JOHNSON MD.</u>		22d. ADDRESS <u>LA PLATA, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-15-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>	23d. LOCATION (City or Town) (County) (State) <u>Parminet, Ches. 1114</u>
24. FUNERAL DIRECTOR <u>The Herditt Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY LaPlata Md, Charles County		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admiss on) a STATE Maryland b COUNTY Charles County	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata Md		c LENGTH OF STAY IN 1b ----- DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Physicians Memorial Hosp LaPlata Md		d STREET ADDRESS Nanjemoy -Md.	
3 NAME OF DECEASED (Type or print) Kenneth Francis Queen		4 DATE OF DEATH 11-25-67	
5 SEX Male	6 COLOR OR RACE N.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-18-68
9 AGE (In years last birthday) 18-Mths		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
10b KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Washington-D.C.	
12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Francis Genard Queen	
14 MOTHER'S MAIDEN NAME Marion Dent		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO None		17 INFORMANT Katie Dent -Grand Mother	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 491X IMMEDIATE CAUSE (a) Pneumonia Broncho. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24-Hrs	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) James E. Andrews MD		22. DATE SIGNED 11-25-67 Indian Head Md	
23a BURIAL CREMATION, RESURRECTION Burial		23b DATE THEREOF 11/27/1967	
23c NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d LOCATION (City or Town) (County) (State) Nanjemoy, Md.	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc. -La Plata, Md.		25a REC'D BY REGISTRAR NOV 29 1967	
25b REGISTRAR'S SIGNATURE 			



FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15307

1 PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Indian Head La Plata c. LENGTH OF STAY IN 1b Waldorf d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Physicians Memorial Hospital		2 USUAL RESIDENCE (Where deceased lived, first full-time residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS 1111 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) EVELYN Alice RENNER		4 DATE OF DEATH Month November Day 23 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 1, 1944
9 AGE (In years last birthday) 23 yrs		10 IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HW		10b KIND OF BUSINESS OR INDUSTRY HW	
11 BIRTHPLACE (State or foreign country) Charles County, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Thomas Brooks		14 MOTHER'S MAIDEN NAME Doris Clements	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO -	
17 INFORMANT Doris Brooks, Waldorf, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8164 (c) 8164		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car - involved in auto accident	
20c TIME OF INJURY Month, Day, Year Hour a.m. 11/23 19 67 p.m. UNK		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street		20f (City or town) (County) (State) Charles, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection on <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		22. DATE SIGNED 11/24/67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Nov. 27, 1967	
23c NAME OF CEMETERY OR CREMATORY St. Peters		23d LOCATION (City or town) (County) (State) Waldorf, Charles Co., Md.	
24 FUNERAL DIRECTOR ADDRESS Arehart Funeral Home Inc., La Plata, Md.		25a REC'D BY REGISTRAR DATE NOV 29 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>MARYLAND</u>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>1</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>George Riley</u>		4 DATE OF DEATH Month <u>11</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>E</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec 18 1906</u>
9 AGE (In years lost birthday) yrs <u>60</u>		10 IF UNDER 1 YEAR <u>1</u> MONTHS <u>15</u> DAYS <u>15</u> HOURS <u>15</u> MIN	
10a USUAL OCCUPATION (Give kind of work done during most of work night, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George Riley</u>		14 MOTHER'S MAIDEN NAME <u>MARY CLARE VERNON</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO.	
17 INFORMANT <u>Charles J. Berry</u>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>8234</u> DUE TO <u>Myocardial infarction</u> (b) <u>Thrombosis of coronary artery</u> DUE TO <u>hypertension</u> (c) <u>atherosclerosis</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day Year Hour <u>4</u> min <u>0</u> pm <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home farm factory, street, office bldg, etc.) <u>Home</u>		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles J. Berry</u> M.D.		22 DATE SIGNED <u>11-15-67</u>	
EXAMINER'S NAME (Type) <u>Charles J. Berry</u>		Address (Street city town, or county)	
23a BURIAL (CREMATION) REMOVAL (Specify)		23b DATE THEREOF <u>11-23-67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>2100 Baptist</u>		23d LOCATION (City or town) (County) (State) <u>Welcome, Charles, Md.</u>	
24 FUNERAL DIRECTOR <u>BERRY FUNERAL Home, Pomonkey, Md</u>		25a REC'D BY REGISTRAR <u>Nov 24 1967</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles J. Berry</u>	



15309

15305

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaPlata				c. LENGTH OF STAY in 1b White Plains, Maryland				2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) White Plains, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hospital								d. STREET ADDRESS St #2 White Plains, Maryland			
3 NAME OF DECEASED (Type or print) First Middle Last ORA MAE SHEGOGUE				4 DATE OF DEATH Month Day Year November 2, 19 67							
5 SEX Female		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 22-1928		9 AGE (In years last birthday) 39 yrs		IF UNDER 1 YEAR Months Days Hours Min 2 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11 BIRTHPLACE (State or foreign country) Washington, DC				12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Merl W. Click						14. MOTHER'S MAIDEN NAME Rose Reed					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO		17. INFORMANT Address Earle H. Shegogue (Husband) Same as # 2.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rheumatic Heart Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspect on <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town or county)					
22. DATE SIGNED 11/2/67											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 6th, 1967		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Bladensburg, Maryland			
24. FUNERAL DIRECTOR Simmons Bros. ADDRESS Simmons Bros. 1661-Gd. Hope Rd. SE. Wash., DC						25a. REC'D BY REGISTRAR NOV 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15206

CERTIFICATE OF DEATH

1967

1 PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospita,		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JAMES L. SMOTHERS		4 DATE OF DEATH Month November Day 25 Year 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1904	9. AGE (In years less birthday) yrs 63	10. IF UNDER 1 YEAR Months 6 Days 10 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Newport, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Smothers		14. MOTHER'S MAIDEN NAME Marym Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-2911		17. INFORMANT Marie S. Banks-Sister-Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure DUE TO Chronic y liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 3-4 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/25 , 19 67 to 11/25 , 19 67 , that (I) (we) last saw the deceased alive on 11/24 , 19 67 , and that death occurred at 6:30 M, from causes and on the date stated above.					
22a. SIGNATURE Antonio M. Monteiro M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/26/1967	
22c. PHYSICIAN'S NAME (Type) Antonio M. Monteiro		22d. ADDRESS La Plata, Charles Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/26/1967	23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		23d. LOCATION (City or Town) (County) (State) Issue, Maryland	
24. FUNERAL DIRECTOR ADDRESS Arehart Funeral Home, Inc.-La Plata, Md.		25a. REC'D BY REGISTRAR NOV 29 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the bur-at-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G395 11/27/67 ph

15307

CERTIFICATE OF DEATH

15311

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Nanjemoy.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physician Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>CROFT</u> Middle <u>WARD</u> Last				4. DATE OF DEATH <u>Nov 16 1967</u> Month <u>Nov</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>15 Aug 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTAL CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FREDERIC CROFT</u>				14. MOTHER'S MAIDEN NAME <u>CORNELIA CARPENTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-2806</u>		17. INFORMANT Address <u>Calvin Compton BRT TOBACCO, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of liver</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Arteriosclerotic vascular disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u> <u>10 days</u> <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1 Nov</u> , 19 <u>67</u> , to <u>16 Nov</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>15 Nov</u> , 19 <u>67</u> , and that death occurred at <u>12:14 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Arthur C. Woody MD</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>16 Nov 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR C. WOODY, MD.</u>				22d. ADDRESS <u>SARWOOD CLINIC, LAPLATA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11-18-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. REST</u>		23d. LOCATION (City or Town) (County) (State) <u>LAPLATA Charles Md</u>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>HUNT FUNERAL HOME</u>		<u>WALDORF, Md.</u>		<u>NOV 21 1967</u>		<u>Charles Judge</u>	

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THE C. T. 1875

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
15308
15312
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicans Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata (Rural) d. STREET ADDRESS 081 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle AUDREY Last WHEELER				4. DATE OF DEATH Month November Day 8 Year 19 67			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 15, 1926	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 41 Min.		11. BIRTHPLACE (County & State, or foreign country) Newburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Newburg, Maryland	
13. FATHER'S NAME Frank M. Wheeler				14. MOTHER'S MAIDEN NAME Martha M. Smallwood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Frank M. Wheeler-Father-La Plata, Md.	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 6000 Uremia DUE TO (b) Chronic Pyelo Nephritis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cirrhosis of the Liver							INTERVAL BETWEEN ONSET AND DEATH 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/31 , 19 67 , to 11/7 , 19 67 , that (I) (we) last saw the deceased alive on 11/7 , 19 67 , and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Arturo M. Monteiro				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/9/67	
22c. PHYSICIAN'S NAME (Type) Arturo M. Monteiro				22d. ADDRESS La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 11/11/1967		23c. NAME OF CEMETERY OR CREMATORY Holy Ghost Cemetery		23d. LOCATION (City, town or county) (State) Issue, Maryland	
24. FUNERAL DIRECTOR Arehart Funeral Home, Inc.-La Plata, Md.				25a. REC'D BY REGISTRAR NOV 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

